Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address
VISTA MEDICAL CENTER HOSPITAL
4301 VISTA ROAD
PASADENA TEXAS 77504

Carrier's Austin Representative Box
Box 47

MFDR Date Received
June 23, 2003

Respondent Name
ZENITH INSURANCE CO

MFDR Tracking Number
M5-03-2847

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated February 17, 2003: "We Have Received Partial Payment For The Above-Referenced Claim In The Amount Of $22,432.40. However, this payment is not accordance with TWCC Rule 134.401. Specifically, TWCC Rule 134.401 requires payment of 75% of audited charges for billed charges that reach the stop-loss threshold of $40,000.00"

Requestor's Position Summary Dated April 2, 2004: "Vista Medical Center Hospital properly filed a request for Medical Dispute Resolution that was received by the Commission on June 23, 2003. The Commission improperly requested additional information for a retrospective medical necessity dispute and improperly deemed that the request for Medical Dispute was not filed until July 7, 2003…Vista Medical Center Hospital respectfully requests the TWCC remand the current decision and issue a proper finding based upon the dates of service from July 5-6, 2002 as Vista Medical Center Hospital is not in dispute of the determination by the hearing officer regarding dates of service July 7-10, 2002."

Amount in Dispute: $66,995.65

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated July 22, 2003: "We have been retained by Zenith Insurance Company to represent its interest in the above-referenced medical dispute."

Response Submitted by: Wilson Grosenheider & Jacobs, L.L.P.

Respondent's Supplemental Position Summary Dated July 24, 2003: "We believe the requestor was reimbursed a fair and reasonable amount for the disputed services."

Response Submitted by: The Zenith

Respondent's Supplemental Position Summary Dated March 29, 2004: "The purpose of this correspondence is to request an appeal of the Finding as Decision (see attached) issued on March 8, 2004 and received on March 9, 2004…"

Response Submitted by: Stone, Loughlin & Swanson, L.L.P., P.O. Box 30111, Austin, TX 78755

Respondent's Supplemental Position Summary Dated December 18, 2012: "The medical records do not demonstrate that this was an outlier case. There is no evidence that Requestor provided services in this case that would not normally be provided to someone receiving the same type of surgery and that were unusually extensive and unusually costly. Furthermore, Requestor has not identified any specific services it contends were unusually extensive and it has not established the unusual cost of those services. In short, Requestor has not met its burden of proof. For these reasons, the Division should not approve reimbursement under the stop-loss exception but should affirm that reimbursement should be pursuant to the standard per diem method."

Response Submitted by: Stone, Loughlin & Swanson, L.L.P., P.O. Box 30111, Austin, TX 78755

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
July 5, 2002 through July 10, 2002	Inpatient Hospital Services	$66,995.65	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6246, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
3. 28 Texas Administrative Code §134.1, 27 *Texas Register* 4047, effective May 16, 2002, sets out the guidelines for a fair and reasonable amount of reimbursement in the absence of a contract or an applicable division fee guideline.
4. 28 Texas Administrative Code §134.600, 26 *Texas Register* 9874, effective January 1, 2002, requires preauthorization for inpatient hospital services.
5. 28 Texas Administrative Code §133.301, 25 *Texas Register* 2115, effective July 15, 2000, addresses retrospective review of medical bills.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Room & Board services, and Implants were reduced for the following reasons:
   - F – Payment based on the assigned Per Diem amount per the 1997 Texas Inpatient Hospital Fee Guideline.
   - M – The amount charged exceeds the maximum usual and customary fee for the same service(s) in the same geographic area.
   - V – Payment has been denied because the carrier deems the treatment(s) and/or service(s) to be medically unreasonable and/or unnecessary based on a peer review judgment.

   All other services were denied for the following reasons:
   - F – Payment based on the assigned Per Diem amount per the 1997 Texas Inpatient Hospital Fee Guideline.
   - M – The amount charged exceeds the maximum usual and customary fee for the same service(s) in the same geographic area.
   - V – Payment has been denied because the carrier deems the treatment(s) and/or service(s) to be medically unreasonable and/or unnecessary based on a peer review judgment.
   - G – Payment for these services is included in the Per Diem amount.

7. Dispute M5-03-2847 History
   - Dispute was originally decided on March 4, 2004.
   - The original dispute decision was appealed to the State Office of Administrative Hearings (SAOH).
   - SOAH issued a decision on August 30, 2007.
   - The SOAH decision was appealed to District Court under case number D-1-GN-07-003314.
   - The 126th Judicial District remanded the dispute to the Division pursuant to an agreed order of remand dated December 1, 2011.
   - As a result of the remand order, the dispute was re-docketed at the Division's medical fee dispute resolution section.
   - Medical fee dispute issued a decision under re-docketed dispute number M5-03-2847-02 on January 4, 2013.
   - M5-03-2847-02 was withdrawn by the Division on January 18, 2013 and was re-docketed under M5-03-2847-03.
   - M5-03-2847-03 is hereby reviewed.

Issues

1. Did the workers' compensation insurance carrier have the authority to retrospectively review the services in dispute?
2. Did the audited charges exceed $40,000.00?
3. Did the admission in dispute involve unusually extensive services?
4. Did the admission in dispute involve unusually costly services?
5. Is the requestor entitled to additional reimbursement?

Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 Texas Register 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this dispute supplemented the original MDR submissions. The division received supplemental positions as noted above. Positions were exchanged among the parties as appropriate. Documentation filed by the requestor and respondent to date is considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals' November 13, 2008 opinion, the division will address whether the total audited charges ***in this case*** exceed $40,000; whether the admission and disputed services ***in this case*** are unusually extensive; and whether the admission and disputed services ***in this case*** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that "Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold…" In that same opinion, the Third Court of Appeals states that the stop loss exception "…was meant to apply on a case-by-case basis in relatively few cases." 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. The respondent denied payment, in part, due to V which states "Payment has been denied because the carrier deems the treatment(s) and/or service(s) to be medically unreasonable and/or unnecessary based on a peer review judgment." Review of documentation titled "Notice of Authorization" dated June 11, 2002, and another titled "Notice of Utilization Review Findings" dated July 9, 2002 finds that Forte, an agent of the respondent, initially preauthorized a 3-day length of stay, and subsequently authorized the remaining 2 days. 28 Texas Administrative Code Rule §133.301(a) states, in pertinent part, that "The insurance carrier shall not retrospectively review the medical necessity of a medical bill for treatment(s) and/or service(s) for which the health care provider has obtained preauthorization." The documentation sufficiently supports that the requestor in this case obtained preauthorization for the disputed surgery/admission. For that reason, the respondent did not have the authority to retrospectively review the medical necessity for the services in this dispute. The Division concludes that denial code "V" is not supported.

2. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000, the minimum stop-loss threshold." Furthermore, 28 Texas Administrative Code §134.401(c)(6)(A)(v) states that "Audited charges are those charges which remain after a bill review by the insurance carrier has been performed." Review of the explanation of benefits issued by the respondent finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal $119,237.40. The Division concludes that the total audited charges exceed $40,000.

3. 28 Texas Administrative Code §134.401(c)(2)(C) allows for payment under the stop-loss exception on a case-by-case basis only if the particular case exceeds the stop-loss threshold as described in paragraph (6). Paragraph (6)(A)(ii) states that "This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission." The Third Court of Appeals' November 13, 2008 opinion states that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved…unusually extensive services" and further states that "independent reimbursement under the Stop-Loss Exception was meant to apply on a case-by-case basis in relatively few cases." In its position, the requestor states:

   > This complex spine surgery is unusually extensive for at least six reasons: first, this surgery as noted above required extensive spinal instrumentation; second, the median length of stay for workers' compensation inpatient admissions is three days, whereas the length of stay for this admission was 5 days; third, this surgery required two surgeons and another physician to monitor somatosensory evoked potentials with an OR time of 4.5 hours; fourth, the patient post-operatively developed several complications including a fever which continued for four days, the patient further required aggressive breathing treatments including albuterol treatments and also developed anemia; fifth, this patient required an internal medicine physician consult prior to surgery and to manage her post-operatively and an acute pain consult to manage the patient's pain; and sixth, this patient had a history of Hepatitis B and Hepatitis C which required extra precautions and protective gear during the surgery.

   The requestor discusses some case-specific medical factors in support of its contention that the disputed services are unusually extensive; however, the requestor fails to discuss or demonstrate how these factors may be considered unusually extensive when compared to similar spinal surgeries, services, or admissions. Furthermore, the requestor has not provided information or documentation to support the basis for its conclusion of a median length of stay for workers' compensation inpatient admissions as being three days. The Requestor does not specify whether any such data concerned Texas hospitals and addressed services in the year 2002 when the services in this matter were provided. Finally, the requestor has not specified what unusually extensive services were provided during the last two days of the hospital stay in this matter. In addition, the hospital's "Discharge Summary" noted, in pertinent parts, that the patient's "slight fever" was treated with antibiotics and that she was subsequently discharged home with good looking incisions and x-rays and without fever. No additional information was found to substantiate why this surgical operation involved unusually extensive services compared with similar operations; therefore, the division finds that the requestor did not meet the requirements of 28 Tex. Admin. Code § 134.401 (c)(6)(A)(ii).

4. 28 Texas Administrative Code §134.401(c)(6) states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The Third Court of Appeals' November 13, 2008 opinion affirmed that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually costly services. The court further held that "What is unusually costly and unusually extensive in any particular fee dispute remains a fact-intensive inquiry best left to the Division's determination on a case-by-case basis…The scope of this authority includes the discretion to determine whether those standards have been met." The Division hereby examines the information and documentation available for the purpose of determining whether the requestor sufficiently supports that the services is dispute were unusually costly.

   In its position, the requestor contends that "The medical and billing records on file with MDR and additional records attached hereto, also show that this admission was unusually costly for two reasons: first, the Medicare outlier threshold amount for this DRG was $70,358.48. Our charges were $119,237.40 for this case. Therefore, this would qualify for additional reimbursement above the DRG reimbursements; and second, it was necessary to purchase expensive implants for use in the surgery, as well as the need to use a cell saver during the procedure."

   The requestor relies upon Medicare's outlier threshold policy as its method to establish that the admission in dispute is unusually costly. The Medicare policy that the requestor relies on may be found at Section

1886(d)(5)(A) of the Federal Social Security Act and in the *Medicare Claims Processing Manual*, CMS Publication 100-04, Chapter 3 found at www.cms.gov. According to this policy, admissions for which a hospital incurs extraordinarily high costs may qualify for payments in addition to the basic Inpatient Prospective Payment System (IPPS) payment. In order to qualify for a so-called "outlier payment" the cost to the hospital for a specific admission must exceed a fixed cost outlier threshold amount. Factors which affect the calculation of the fixed cost outlier threshold amount may change and are updated annually as part of the Inpatient Prospective Payment System (IPPS) final rule, or when relevant, final rules are implemented in Medicare.

In its attempt to support its position that the service in dispute would have qualified for a Medicare outlier payment, the Division finds that:

- the requestor misapplies Medicare's outlier policy by comparing its alleged outlier threshold amount to its total **billed** charges, rather than the **costs to the hospital** for the admission in dispute;
- the requestor overlooks the fact that within the Texas Labor Code, total billed charges are not a valid indicator of cost as explained in the preamble to 28 Texas Administrative Code §134.401, 22 *Texas Register* 6246, effective August 1, 1997.
- the requestor fails to calculate or reasonably estimate the total costs to the hospital for the services in dispute;
- the requestor fails to demonstrate how it arrived at its alleged outlier threshold amount of $70,358.48; and
- the requestor did not demonstrate that factors used to determine its outlier threshold were appropriate for the dates of service involved in the admission.

Although the requestor adds that the costs to the hospital were "increased" due to the purchase expensive implants for use in the surgery and the use a cell saver, the requestor fails to discuss or demonstrate how these costs were unusual when compared to similar surgeries or admissions. For all the reason stated, the Division concludes that the requestor has failed to support that the service in dispute were unusually costly.

5. For the reasons stated above, the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) subtitled *Standard Per Diem Amount* and §134.401(c)(4) subtitled *Additional Reimbursements.* The Division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.

   - 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission." Review of the submitted documentation finds that the length of stay for this admission was five surgical days, all of which were preauthorized by the workers' compensation insurance carrier; therefore, the standard per diem amount of $1,118.00 applies. The per diem rate multiplied by the length of stay results in a total allowable amount of $5,590.00.

   - 28 Texas Administrative Code §134.401(c)(4)(A), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278); and (ii) Orthotics and prosthetics (revenue code 274)." Review of the requestor's medical bills finds that 24 items were billed under revenue code 0278. These items are eligible for separate payment under §134.401(c)(4)(A) as follows:

Itemized Statement Description		Cost Invoice Description	Units	Cost	Cost + 10%
0000904	POLY SCREWS 6X4 0MM	Sacral Screw Poly 6x40	2	$968.00 x 2 = $1,936.00	$2,129.60
0001127	BRANTIGAN CAGE 13X11	Lumbar Cage	2	$2595.00 x 2 = $5,190.00	$5,709.00
0001266	12 CM ROD	Rod 12cm	2	$255.00 x 2 = $510.00	$561.00
0002261	BRANTIGAN CAGE 9X9	Cage	2	$2490.00 x 2 = $4,980.00	$5,478.00
0002313	INNER SCREW 1755-26	Inner Screw	6	$70.00 x 6 = $420.00	$462.00

00023 14	OUTER NUT #1755-27	Outer nut	6	$78.00 x 6 = $468.00	$514.80
00032 60	6X35 POLYSCREW	Sacral Screw Poly 6x35	2	$960.00 x 2 = $1,920.00	$2,112.00
00035 78	POLY SCREW	Sacral Screw Poly 6x35	2	$960.00 x 2 = $1,920.00	$2,112.00
				TOTAL	$19,078.40

The division concludes that the total allowable reimbursement for this admission is the SPDA of $5,590.00, plus $19,078.40 for the implantables, which equals $24,668.40. The respondent issued payment in the amount of $22,432.40. Based upon the documentation submitted, additional reimbursement in the amount of $2,236.00 is recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed $40,000, but failed to demonstrate that the disputed inpatient hospital admission involved unusually extensive services, and failed to demonstrate that the services in dispute were unusually costly. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount,* and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in additional reimbursement.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The division hereby ORDERS the respondent to remit to the requestor the amount of $2,236.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Manager	December 18, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812